Guide

To Health Insurance for People with Medicare

1987

Some Basic Things You Should Know

Hints on Shopping for Private Health Insurance

Types of Private Health Insurance

What Medicare Pays and Doesn't Pay

Developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration of the U.S. Department of Health and Human Services.

THE MEDICARE INFORMATION IN THIS PAMPHLET IS FOR 1987. IT WILL CHANGE FROM YEAR TO YEAR. FOR A MORE DETAILED AND CURRENT EXPLANATION OF MEDICARE AND ITS BENEFITS, OBTAIN A FREE COPY OF *A BRIEF EXPLANATION OF MEDICARE* FROM YOUR LOCAL SOCIAL SECURITY OFFICE.

SOME BASIC THINGS YOU SHOULD KNOW—Medicare pays a large part of your health care expenses. It does not pay them all. There are limits on some covered services and you must pay certain amounts called deductibles and co-payments.

Medicare does not cover some services at all. Neither does most private insurance. For example:

- What many people think of as nursing home care is not usually covered by Medicare or insurance policies on the market today. (See page 8.)
- Medicare and most private health insurance policies pay only a specified percent of the amount approved by Medicare. You pay the rest. To avoid extra charges, ask your doctor if he or she participates or accepts assignment of Medicare benefits. Assignment means that your doctor (or other supplier) agrees to accept the amount approved by Medicare as the total charge for covered services and supplies. Participating doctors or suppliers accept assignment on all Medicare claims. (See page 17.)
- Insurance to supplement Medicare is not sold or serviced by the government. Do not believe advertising or agents who suggest that Medicare supplement insurance is a government sponsored program.

Before you consider buying insurance to supplement Medicare, you should know what Medicare benefits are. Pages 9 through 18 explain your Medicare coverage. Please review them carefully.

DO YOU NEED PRIVATE HEALTH INSURANCE IN ADDITION TO MEDICARE? Not everyone does. . .

- Low-income people who are eligible for Medicaid generally do not need additional insurance. Medicaid pays almost all costs including long-term nursing care. Contact your local social service agency to find out if you qualify and what the benefits are in your state.
- Whether you need health insurance in addition to Medicare is a decision which you should discuss with someone you know who understands insurance and your financial situation. The best time to do this is before you reach age 65.

HINTS ON SHOPPING FOR PRIVATE HEALTH INSURANCE—Shop Carefully Before You Buy . . . policies differ widely as to coverage and cost, and companies differ as to service. Contact different companies and compare the policies carefully before you buy.

Don't Buy More Policies Than You Need... Duplicate coverage is costly and not necessary. A single comprehensive policy is better than several policies with overlapping or duplicate coverages. For comprehensive coverage, consider continuing the group coverage you have at work; joining an HMO; buying a catastrophic or major medical policy or buying a Medicare Supplement policy. (See pages 6 and 7.)

Check For Preexisting Condition Exclusions . . .which reduce or eliminate coverage for existing health conditions. Many policies exclude coverage for preexisting health conditions.

Don't be misled by the phrase "no medical examination required." If you have had a health problem, the insurer might not cover you for expenses connected with that problem.

Beware of Replacing Existing Coverage. . . be suspicious of a suggestion that you give up your policy and buy a replacement. Often the new policy will impose waiting periods or will have exclusions or waiting periods for preexisting conditions your current policy covers. On the other hand, don't keep inadequate policies simply because you have had them a long time. You don't get credit with a company just because you've paid many years for a policy.

Be Aware of Maximum Benefits . . . most policies have some type of limit on benefits which may be expressed in terms of dollars payable or the number of days for which payment will be made.

Check Your Right To Renew . . . beware of policies that let the company refuse to renew your policy on an individual basis. These policies provide the least permanent coverage.

Most policies cannot be canceled by the company unless all policies of that type are canceled in the state. Therefore, these policies cannot be canceled because of claims or disputes. Some policies are guaranteed renewable for life. Policies that can be renewed automatically offer added protection.

Policies to Supplement Medicare Are Neither Sold nor Serviced by State or Federal Government . . . State Insurance Departments approve policies sold by insurance companies but approval only means the company and policy meet requirements of state law. Do not believe statements that insurance to supplement Medicare is a government-sponsored program. If anyone tells you that he or she is from the government and later tries to sell you an insurance policy, report that person to your State Insurance Department. This type of representation is a violation of Federal law.

Know With Whom You're Dealing . . . a company must meet certain qualifications to do business in your state. This is for your protection. Agents also must be licensed by your state and must carry proof of licensing showing their name and the company they represent. If the agent cannot show such proof, do not buy from that person. A business card is not a license.

Keep Agents' and/or Companies' Names, Addresses and Telephone Numbers . . . write down the agents' and/or companies' names, addresses and telephone numbers; or ask for a business card.

Take Your Time . . . do not let a short-term enrollment period high pressure you. Professional salespeople will not rush you. If you question whether a program is worthy, ask the salesperson to explain it to a friend or relative whose judgment you respect. Allow yourself time to think through your decision.

IF YOU DECIDE TO BUY– **Complete Application Carefully** . . . some companies ask for detailed medical information. If they do and you omit the requested medical information, the company can refuse coverage for an omitted condition for a period of time or it may deny a claim and/or cancel your policy. Do not believe anyone who tells you that your medical history on an application is not important.

Look for an Outline of Coverage . . . you should be given a clearly worded summary of the policy . . . READ IT CAREFULLY.

Do Not Pay Cash . . . pay by check, money order or bank drafts made payable to the insurance company, not the agent or anyone else.

Check For a Free Look Provision . . . most companies give you at least 10 days to review the policy. If you decide you don't want to keep it, send it back to the agent or company within 10 days of receiving it and you will get a refund of all premiums you have paid.

Policy Delivery or Refunds Should be Prompt . . . the insurance company should deliver a policy within 30 days. If not, contact the company and obtain in writing a reason for failure to deliver. If 60 days go by without information, contact your State Insurance Department. The same schedule should be followed if you return the policy but do not receive your refund.

For Your Protection . . . Federal criminal penalties can be imposed against any company or agent who knowingly sells you a policy that duplicates Medicare coverage or any private health insurance that you

already own but which will not pay duplicate benefits, or suggests that they represent the Medicare program or any Government agency. If you believe you have been the victim of these or any other illegal sales practices, you should contact your State Insurance Department.

TYPES OF PRIVATE HEALTH INSURANCE Private health insurance is available through group and individual policies. It is offered by some companies through agents and by other companies directly through advertising media and mail. Coverage offered and their values differ widely among both group and individual policies.

Types of individual and group health insurance coverages

- **Medicare Supplement** . . . pays some or all of Medicare's deductibles and co-payments. Some policies may also pay for some health services not covered by Medicare. (See page 9.) Medicare pays only for services determined to be medically necessary and only to the extent of what Medicare determines to be the approved amount. (See page 16.) Most Medicare supplements follow the same guidelines and pay nothing for services Medicare finds unnecessary.
- **Catastrophic or Major Medical Expense** . . . helps cover the high cost of serious illness or injury, including some health services not covered by Medicare. These policies usually have a large deductible and may not cover Medicare's co-payments and deductibles. If this type policy is available in

your area, it can be a better dollar value to insure only for catastrophic expenses than to buy coverage for the Medicare deductibles and co-payments.

- **Health Maintenance Organizations (HMOs)** . . . there may be one or more HMOs in your area which participate in the Medicare program. HMOs both insure health care and provide the service. People who join HMOs pay a membership fee, or premium, and then receive health services directly from physicians and other providers affiliated with HMOs. Services are prepaid, so there are usually no claims forms to process. For Medicare covered services, there are usually no separate charges for deductibles or co-payments. If you are willing to receive your care from a specified group of providers, HMOs may provide the most complete service for your health care dollar.

Group insurance is available through employers and through voluntary associations.

- **Employer Group Insurance** . . . many people are covered by a group plan while they are employed. Find out before you retire if your group coverage can be continued or converted to a suitable individual Medicare supplement policy when you reach age 65. Check carefully the price and the benefits, including benefits for your spouse. Employer continued or conversion group insurance usually has the advantage of having no waiting periods or preexisting condition exclusions. Consult your employer

for information about special rules that apply to employer group coverage for people who continue to work after they reach age 65.

- **Association Group Insurance** . . . many organizations, other than employers, offer various kinds of group health insurance coverage to their members over age 65.

  Beware of claims of low group rates because coverage under group policies may be as expensive or more costly than comparable coverage under individual policies. Be sure you understand the benefits included and then compare prices.

The following coverages are limited in scope and are not substitutes for Medicare Supplement, Catastrophic, Major Medical Expenses or HMOs.

- **Nursing Home Coverage** . . . usually pays a stated amount a day for required skilled nursing service furnished in a skilled nursing facility. Intermediate care, rest care and custodial care are generally not covered under any policy on the market today. Most people in nursing homes are receiving custodial care. Be sure you know which nursing homes and services are covered.

- **Hospital Confinement Indemnity Coverage** . . . pays a fixed amount for each day your are hospitalized up to a designated number of days. Some coverage may have added benefits such as surgical benefits or skilled nursing

home confinement benefits. Premiums do not ordinarily increase but the fixed benefits do not rise to meet increasing costs of hospitalization.

- **Specified Disease Coverage** . . . (not available in some states) . . . provides benefits for only a single disease, such as cancer, or a group of specified diseases.

  The value of such coverage depends on the chance you will get the specific disease or diseases covered. Benefits are usually limited to payment of a fixed amount for each type of treatment. Benefits are not designed to fill the Medicare gaps.

WHAT MEDICARE PAYS AND DOESN'T PAY – Medicare is divided into two parts—hospital insurance (Part A) and medical insurance (Part B). Pages 12 through 14 describe Part A benefits and pages 15 and 16 describe Part B benefits. The chart on pages 10 and 11 gives brief outlines of both Part A and Part B. Please refer to *Your Medicare Handbook* or any Social Security office for more information.

Medicare does not pay the entire cost for all covered services. You pay for deductibles and co-payments. A *deductible* is an initial dollar amount which Medicare does not pay . . . a *co-payment* is your share of expenses for covered services above the deductible.

MEDICARE (PART A): HOSPITAL INSURAN	
Service	**Benefit**
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 da
	61st to 90th
	91st to 150th
	Beyond 150
POSTHOSPITAL SKILLED NURSING FACILITY CARE . . . In a facility approved by Medicare. You must have been in a hospital for at least 3 days and enter the facility within 30 days after hospital discharge. (2)	First 20 da
	Additional 8(
	Beyond 100
HOME HEALTH CARE	Visits limit to medical nec
HOSPICE CARE	Two 90-day p and one 30-day
BLOOD	Blood

*60 Reserve Days may be used only once; days used are no
**These figures are for 1987 and are subject to change ea
(1) A Benefit Period begins on the first day you receive servi the hospital or skilled nursing facility for 60 days in a r
(2) Medicare and private insurance will not pay for most nurs home.

MEDICARE (PART B): MEDICAL INSURAN	
Service	**Benefit**
MEDICAL EXPENSE Physician's services, inpatient and outpatient medical services and supplies, physical and speech therapy, ambulance, etc.	Medicare pays fo services in or ou hospital. Some i policies pay (or nothing) for outpatient medic or services in a office.
HOME HEALTH CARE	Visits limit to medical nec
OUTPATIENT HOSPITAL TREATMENT	Unlimited medicall necessar
BLOOD	Blood

*Once you have had $75 of expense for covered services in 19 ices you receive the rest of the year.
**YOU PAY FOR charges higher than the amount approved approved amount as the total charge for services rendered

COVERED SERVICES PER BENEFIT PERIOD(1)		
	Medicare Pays**	**You Pay****
	All but $520	$520
	All but $130 a day	$130 a day
	All but $260 a day	$260 a day
	Nothing	All costs
	100% of approved amount	Nothing
	All but $65 a day	$65 a day
	Nothing	All costs
	Full cost	Nothing
d	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
	All but first 3 pints	For first 3 pints

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n inpatient in a hospital and ends after you have been out of

me care. You pay for custodial care and most care in a nursing

COVERED SERVICES PER CALENDAR YEAR		
	Medicare Pays	**You Pay**
cal ne ce tal ices 's	80% approved amount (after $75 deductible)	$75 deductible* plus 20% of balance of approved amount (plus any charge above approved amount)**
	Full cost	Nothing
	80% of approved amount (after $75 deductible)	Subject to deductible plus 20% of balance of approved amount
	80% of approved amount (after $75 deductible and starting with 4th pint)	First 3 pints plus 20% of approved amount (after $75 deductible)

e Part B deductible does not apply to any further covered serv-

dicare unless the doctor or supplier agrees to accept Medicare's

page 16.)

MEDICARE (PART A): HOSPITAL INSURANCE—COVERED SERVICES PER BENEFIT PERIOD(1)

Service	Benefit	Medicare Pays**	You Pay**
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but $520	$520
	61st to 90th day	All but $130 a day	$130 a day
	91st to 150th day*	All but $260 a day	$260 a day
	Beyond 150 days	Nothing	All costs
POSTHOSPITAL SKILLED NURSING FACILITY CARE . . . In a facility approved by Medicare. You must have been in a hospital for at least 3 days and enter the facility within 30 days after hospital discharge. (2)	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but $65 a day	$65 a day
	Beyond 100 days	Nothing	All costs
HOME HEALTH CARE	Visits limited to medical necessity	Full cost	Nothing
HOSPICE CARE	Two 90-day periods and one 30-day period	All but limited costs for outpatient dtugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
BLOOD	Blood	All but first 3 pints	For first 3 pints

*60 Reserve Days may be used only once; days used are not renewable.

**These figures are for 1987 and are subject to change each year.

(1) A Benefit Period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital or skilled nursing facility for 60 days in a row.

(2) Medicare and private insurance will not pay for most nursing home care. You pay for custodial care and most care in a nursing home.

MEDICARE (PART B): MEDICAL INSURANCE—COVERED SERVICES PER CALENDAR YEAR

Service	Benefit	Medicare Pays	You Pay
MEDICAL EXPENSE Physician's services, inpatient and outpatient medical services and supplies, physical and speech therapy, ambulance, etc.	Medicare pays for medical services in or out of the hospital. Some insurance policies pay less (or nothing) for hospital outpatient medical services or services in a doctor's office.	80% approved amount (after $75 deductible)	$75 deductible* plus 20% of balance of approved amount (plus any charge above approved amount)**
HOME HEALTH CARE	Visits limited to medical necessity	Full cost	Nothing
OUTPATIENT HOSPITAL TREATMENT	Unlimited as medically necessary	80% of approved amount (after $75 deductible)	Subject to deductible plus 20% of balance of approved amount
BLOOD	Blood	80% of approved amount (after $75 deductible and starting with 4th pint)	First 3 pints plus 20% of approved amount (after $75 deductible)

*Once you have had $75 of expense for covered services in 1987, the Part B deductible does not apply to any further covered services you receive the rest of the year.

**YOU PAY FOR charges higher than the amount approved by Medicare unless the doctor or supplier agrees to accept Medicare's approved amount as the total charge for services rendered. (See page 16.)

MEDICARE HOSPITAL INSURANCE BENEFITS (PART A)

WHAT MEDICARE PART A PAYS

When all program requirements are met, Medicare Part A will help pay for medically necessary in-hospital care, for medically necessary inpatient care in a skilled nursing facility after a hospital stay, and for hospice care. In addition, Part A pays the full cost of medically necessary home health care.

Part A covers all services customarily furnished by hospitals and skilled nursing facilities. Part A does not cover private duty nursing, charges for a private room unless medically necessary, or convenience items such as telephones or television. Part A also does not cover the first 3 pints of blood you receive during an inpatient stay (but you cannot be charged for blood if it is replaced by a blood plan or through a blood donation in your behalf).

BENEFIT PERIODS

Medicare Part A benefits are paid on the basis of benefit periods. A benefit period begins the first day you receive Medicare covered service in a hospital and ends when you have been out of a hospital or skilled nursing facility for 60 days in a row. If you enter a hospital again after 60 days, a new benefit period begins. All Part A benefits (except for reserve days you have used) are renewed. There is no limit to the number of benefit periods you can have for hospital or skilled nursing facility care. However, special limited benefit periods apply to hospice care. (See page 14.)

INPATIENT HOSPITAL CARE

Part A pays for all covered services for the first 60 days of inpatient hospital care in a benefit period except for $520, the 1987 Part A deductible. For the next 30 days, Part A pays for all covered services except for $130 a day. Every person enrolled in Part A also has a 60-day reserve for inpatient hospital care which can be drawn from if more than 90 days are needed in a benefit period. When reserve days are used, Part A pays for all covered services except for $260 a day. Once used, reserve days are not renewable.

SKILLED NURSING FACILITY CARE

A skilled nursing facility is a special kind of facility which primarily furnishes skilled nursing and rehabilitation services. It may be a separate facility or a part of a hospital. Medicare benefits are payable only if the skilled nursing facility is certified by Medicare. Most nursing homes in the United States are not skilled nursing facilities and many skilled nursing facilities are not certified by Medicare.

Part A pays for all covered services for the first 20 days of medically necessary inpatient skilled nursing facility care during a benefit period. In 1987, for the next 80 days, Part A pays all except $65 a day.

Medicare Part A will not cover your stay in a skilled nursing facility if the services you receive are mainly personal care or custodial services, such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicine.

HOME HEALTH CARE

Part A pays the cost of all *medically necessary* home health visits. Part A covers part-time services of a visiting nurse or physical or speech therapist from a Medicare certified home health agency. If you receive any of these services, Part A can also cover part-time home health aide services, occupational therapy, medical social services and medical supplies and equipment. Part A does not cover full-time nursing care, drugs, meals delivered to your home or homemaker services that are primarily to assist you in meeting personal care or housekeeping needs.

HOSPICE CARE

Under certain conditions, Part A can pay for hospice care for people who have a terminal illness. Part A can pay for a maximum of two 90-day hospice benefit periods and one 30-day period. During a hospice benefit period, Part A pays the full cost of all medical and support services necessary for the symptom management and pain relief of a terminal illness. Covered services include the following, when provided by a Medicare-certified hospice: physician services, nursing care, medical appliances and supplies (including outpatient drugs for symptom management and pain relief), short-term inpatient care, counseling, therapies, and home health aide and homemaker services. There are no deductibles or copayments except for limited cost sharing for outpatient drugs and inpatient respite care.

MEDICARE MEDICAL INSURANCE BENEFITS (PART B)

WHAT MEDICARE PART B PAYS

Medicare Part B helps pay for doctors' bills and many other medical services. You are automatically enrolled in Part B when you enroll in Medicare Part A . . . although you may state that you don't want it. In 1987 the Part B premium is $17.90 a month.

YOU DON'T HAVE TO PURCHASE PART B . . . BUT IT IS AN EXCELLENT BUY BECAUSE THE FEDERAL GOVERNMENT PAYS ABOUT THREE-QUARTERS OF THE ACTUAL COST.

You pay the first $75 of approved charges in 1987. (This is the 1987 Part B deductible.) After that, Medicare Part B generally pays 80% of the amount Medicare approves for covered services you receive the rest of the year. You pay the remaining 20%. This is the Part B co-payment. Unless your doctor or supplier accepts assignment (see page 17), you are responsible for charges above the amount Medicare approves.

SERVICES COVERED

- Physicians' and surgeons' services no matter where you receive them . . . at home, in the doctor's office, in a clinic or in a hospital. Routine physical exams are excluded.

- Home health visits . . . Medicare pays the full cost of medically necessary home health visits. You have no deductible or co-payment.
- Physical therapy and speech pathology services in a doctor's office or as an outpatient and, on a limited basis, in your home.
- Other medical services and supplies . . . such as outpatient hospital services; X-rays and laboratory tests; certain ambulance services; and purchase or rental of durable medical equipment, such as wheelchairs.

Part B will not pay for any services which Medicare does not consider medically necessary . . . neither will most insurance policies.

APPROVED AMOUNT

In deciding whether a charge is "reasonable" Medicare reviews each year the usual charge by the doctor or supplier for each covered service, and the charge of other doctors and suppliers in the area for the same service. The amount approved is often lower then the actual charge made by the doctor or supplier.

Most insurance policies you can buy to supplement Medicare only pay 20% of Medicare's approved amount. You might not get 100% coverage for your Part B bills even if you have Medicare Part B and private insurance. Here's how this could happen:

Suppose your doctor charges you $400 for an operation and Medicare determines the approved amount to be $300. Assuming you have already met the annual Part B deductible, Medicare would pay 80% of the $300, or $240. Most insurance policies would pay 20% of the $300, or $60. You would pay $100—the difference between your doctor's actual charge and Medicare's approved amount. However, you may avoid this extra payment if your doctor accepts assignment.

ASK ABOUT ASSIGNMENT AND PARTICIPATING DOCTORS OR SUPPLIERS

Because you can't tell in advance whether the approved amount and the actual charge will be the same, always ask your doctors or other medical suppliers, such as laboratories and therapists, if they will accept assignment of Medicare benefits. Assignment means that the doctor or supplier will accept Medicare's approved amount as full payment and cannot legally bill you for anything above that amount. In the example above, if your doctor agreed to assignment, he or she would accept $300 as payment in full and you would not have to pay the $100 difference yourself. Doctors and suppliers do not have to accept assignment, but many do.

Also, doctors and suppliers can now become Medicare-*participating* doctors or suppliers who agree to accept assignment

on all Medicare claims. These doctors and suppliers are listed in the *Medicare Participating Physician/Supplier Directory* which is distributed to senior citizen organizations, all local Social Security and Railroad Retirement offices, and all State and area offices of the Administration on Aging. This directory can be purchased from the insurance carrier that processes Medicare Part B claims in your area (see the back of *Your Medicare Handbook* for the list of carrier addresses) or you can call the carrier to find out which doctors and suppliers are participating.

EXPENSES NOT COVERED BY MEDICARE

Medicare does not cover certain kinds of care. Most private insurance does not cover them either. Among them are:

- Private duty nursing.
- Skilled nursing home care costs (beyond what is covered by Medicare).
- Custodial nursing home care costs.
- Intermediate nursing home care costs.
- Physician charges (above Medicare's approved amount).
- Drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay or outpatient drugs for symptom management or pain relief provided by a hospice).
- Care received outside the U.S.A., except under certain conditions in Canada and Mexico.

- Dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for and the cost of eyeglasses or hearing aids.

FOR ADDITIONAL HELP . . .

If you need additional help or advice on Medicare benefits or eligibility, contact your nearest Social Security office or the Health Care Financing Administration.

For information on private insurance to supplement Medicare, check your State Insurance Department or State Consumer Protection Agency.

If you bought or are considering buying a health insurance policy, the company or its agent should answer your questions. If you do not get the service you feel you deserve, discuss the matter with your State Insurance Department.

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